RADIOLOGY

X-RAY SERVICES

Repeat X-Rays

No payment will be made for excessive or unnecessary x-rays. Repeat or serial x-rays may be performed only upon adequate clinical justification to confirm changes in the accepted condition(s) when need is supported by documented changes in objective findings or subjective complaints.

Number of Views

There is no code that is specific for "additional views" for radiology services. Therefore, the number of views of x-rays that may be paid is determined by the CPT® description for the particular service.

For example, the following CPT® codes for radiologic exams of the spine are payable as outlined below:

CPT® Code	Payable
72020	Once for a single view
72040	Once for two to three views
72050	Once for four or more views
72052	Once, regardless of the number of views it takes to complete the series

-RT and -LT Modifiers

HCPCS modifiers -RT (right side) and -LT (left side) do *not affect payment*, but may be used with CPT® radiology codes 70010-79999 to identify duplicate procedures performed on opposite sides of the body.

Portable X-Rays

Radiology services furnished in the patient's place of residence are limited to the following tests, which must be performed under the general supervision of a physician:

- Skeletal films involving extremities, pelvis, vertebral column or skull
- Chest or abdominal films that do not involve the use of contrast media
- Diagnostic mammograms

HCPCS codes for transportation of portable x-ray equipment R0070 (one patient) or R0075 (multiple patients) may be paid in addition to the appropriate radiology code(s).

Custody

X-rays must be retained for ten years. See WAC 296-23-140(1)

CONSULTATION SERVICES

CPT® code 76140, x-ray consultation, is not covered. For radiology codes where a consultation service is performed, providers should bill the specific x-ray code with the modifier

-26. For example, if a consultation is made on a chest x-ray, single view, frontal, the provider should bill 71010-26.

Separate payment will not be made for review of films taken previously or elsewhere if a face-to-face service is performed on the same date as the x-ray review. Review of records and diagnostic studies is bundled into the E/M, chiropractic care visit or other procedure(s) performed.

Payment for a radiological consultation will be made at the established professional component (modifier -26) rate for each specific radiology service. A written report of the radiology consultation is required.

CONTRAST MATERIAL

Separate payment will not be made for contrast material unless a patient requires low osmolar contrast media (LOCM). LOCM may be used in intrathecal, intravenous, and intra-arterial injections for patients with one or more of the following conditions:

- A history of previous adverse reaction to contrast material, with the exception of a sensation of heat, flushing, or a single episode of nausea or vomiting,
- A history of asthma or allergy,
- Significant cardiac dysfunction including recent imminent cardiac decompensation, arrhythmias, unstable angina pectoris, recent myocardial infarction, and pulmonary hypertension,
- Generalized severe debilitation, or
- Sickle cell disease.

To bill for LOCM, use the appropriate HCPCS code, A4644, A4645 or A4646. The brand name of the LOCM and the dosage must be documented in the patient's chart. HCPCS codes and payment levels are listed in the Professional Services Fee Schedule.

Billing Tip HCPCS codes A4644, A4645 and A4646 are paid at a flat rate based on the Average Wholesale Price (AWP) per ml. Bill one unit per ml.

NUCLEAR MEDICINE

The standard multiple surgery policies apply to the following radiology codes for nuclear medicine services.

CPT® Code	Abbreviated Description
78306	Bone imaging, whole body
78320	Bone imaging (3D)
78802	Tumor imaging, whole body
78803	Tumor imaging (3D)
78806	Abscess imaging, whole body
78807	Nuclear localization/abscess

The multiple procedures reduction will be applied when these codes are billed:

- With other codes that are subject to the standard multiple surgery policy, and
- For the same patient, on the same day, by the same physician or by more than one physician of the same specialty in the same group practice.

Refer to the "Surgery Services" section for more information about the standard multiple surgery payment policies.

PHYSICAL MEDICINE

GENERAL INFORMATION

Units of Service

Supervised modalities and therapeutic procedures that do not list a specific time increment in their description are limited to one unit per day.

Non-Covered and Bundled Codes

The following physical medicine codes are not covered:

Code	Abbreviated Description
CPT® 97005	Athletic train eval
CPT® 97006	Athletic train reeval
CPT® 97033	Iontophoresis, each 15 min
CPT® 97545*	Work hardening/conditioning
CPT® 97546*	Each additional hour
CPT® 97781	Acupuncture
HCPCS Q0086	PT evaluation/treatment, per visit

* Work hardening services are paid with local codes only to approved providers.

The following are examples of bundled items or services:

- CPT® code 97010, application of hot or cold packs
- Ice packs, ice caps and collars
- Electrodes and gel
- Activity supplies used in work hardening, such as leather and wood
- Exercise balls
- Thera-taping
- Wound dressing materials used during an office visit and/or physical therapy treatment

Refer to the appendices for complete lists of non-covered and bundled codes.

PHYSICAL CAPACITIES EVALUATION

The following local code is payable only to physicians who are board qualified or certified in physical medicine and rehabilitation, and physical and occupational therapists.

1045M Performance-based physical capacities evaluation with report and summary of capacities..... $ 613.53

PHYSICAL MEDICINE AND REHABILITATION (PHYSIATRY)

Medical or Osteopathic physicians who are board qualified or board certified in physical medicine and rehabilitation may be paid for CPT® codes 97001 through 97799. CPT® code 64550, application neurostimulator (TENS), is payable only once per claim.

NON-BOARD CERTIFIED/QUALIFIED PHYSICAL MEDICINE PROVIDERS

Special payment policies apply for attending doctors who are not board qualified or certified in physical medicine and rehabilitation:

- Attending doctors who are not board qualified or certified in physical medicine and rehabilitation will not be paid for CPT® codes 97001 - 97799. They may *perform* physical medicine modalities and procedures described in CPT® codes 97001 - 97750 if their scope of practice and training permit it, but must *bill* local code 1044M for these services.
- Local code 1044M is limited to six visits per claim, except when the attending doctor practices in a remote location where no licensed, registered physical therapist is available.
- After six visits, the patient must be referred to a licensed, registered physical therapist or physiatrist for such treatment. Refer to WAC 296-20-290 for more information.

1044M Physical medicine modality(ies) and/or procedure(s) by attending doctor who is not board qualified or certified in physical medicine and rehabilitation. Limited to first six visits except when doctor practices in a remote area..... $37.88

PHYSICAL AND OCCUPATIONAL THERAPY

Physical and occupational therapists should use the appropriate physical medicine CPT® codes 97001-97799, with the exceptions noted later in this section. In addition, physical and occupational therapists should bill the appropriate covered HCPCS codes for miscellaneous materials and supplies. For information on surgical dressings dispensed for home use, refer to WAC 296-23-220 or to the "Supplies, Materials and Bundled Services" section.

If more than one patient is treated at the same time in a group setting, use CPT® code 97150, group therapeutic procedures.

Daily Maximum for Services

The daily maximum allowable fee for physical and occupational therapy services is $102.65 (see WACs 296-23-220 and -230). The daily maximum applies to CPT® codes 64550 and 97001-97799 when performed for the same patient for the same date of service. If both physical and occupational therapy services are provided on the same day, the daily maximum applies *once* for each provider type.

The daily maximum allowable fee does not apply to performance based physical capacities examinations (PCEs), work hardening services or job/pre-job accommodation consultation services billed with local codes.

Physical and Occupational Therapy Evaluations

Physical and occupational therapy evaluations should be billed with CPT® codes 97001 through 97004 according to the table below.

Provider	Initial Evaluation	Re-evaluation
Physician or Physical Therapist	CPT® 97001	CPT® 97002
Physician or Occupational Therapist	CPT® 97003	CPT® 97004

CPT® codes 97001 and 97003 are used to report the initial evaluation before the plan of care is established by the physician or therapist. The purpose of the initial evaluation is to evaluate the patient's condition and establish a plan of care.

CPT® codes 97002 and 97004 are used to report the re-evaluation of a patient who has been under a plan of care established by the physician or therapist. This evaluation is for the purpose of re-evaluating the patient's condition and revising the plan of care under which the patient is being treated.

Wound Debridement

Therapists may not bill the surgical CPT® codes for wound debridement. Therapists must bill CPT® 97601 or 97602 when performing wound debridement that exceeds what is incidental to a therapy (e.g. whirlpool).

Wound dressings and supplies used in the office are bundled and are not separately payable. Wound dressings and supplies sent home with the patient for self-care can be billed with HCPCS codes appended with local modifier -1S. See the "Supplies, Materials and Bundled Services" section for more information.

OSTEOPATHIC MANIPULATIVE TREATMENT

Only osteopathic physicians may bill osteopathic manipulative treatment (OMT) using CPT® codes 98925 through 98929. CPT® code 97140, manual therapy, is not covered for osteopathic physicians.

For OMT services (CPT® codes 98925-98929) body regions are defined as: head region, cervical region, thoracic region, lumbar region, sacral region, pelvic region, lower extremities, upper extremities, rib cage region, abdomen and viscera region.

These codes ascend in value to accommodate the additional body regions involved. Therefore, only one code is payable per treatment. For example, if three body regions were manipulated, one unit of CPT® code 98926 would be payable.

OMT includes pre- and post-service work (e.g. cursory history and palpatory examination). E/M office visit services are not to be routinely billed in conjunction with OMT. E/M office visit service (CPT® codes 99201-99215) may be billed in conjunction with OMT *only when all of the following conditions are met*:

- When the E/M service constitutes a significant separately identifiable service that exceeds the usual pre- and post-service work included with OMT.
- There is documentation in the patient's record supporting the level of E/M billed.
- The E/M service is billed using the -25 modifier. E/M codes billed on the same day as OMT without the -25 modifier will not be paid.

The E/M service may be caused or prompted by the same diagnosis as the OMT service. A separate diagnosis is not required for payment of E/M in addition to OMT services on the same day.

The department or Self-Insurer may reduce payment or process recoupments when E/M services are not documented sufficiently to support the level of service billed. The CPT® book describes the key components that must be present for each level of service.

CHIROPRACTIC SERVICES

Chiropractic physicians should use the codes listed in this section to bill for services. In addition chiropractic physicians should use the appropriate CPT® codes for radiology, office visit and case management services and HCPCS codes for miscellaneous materials and supplies.

Evaluation and Management

Chiropractic physicians may bill the first four levels of CPT® new and established patient office visit codes (99201-99204 and 99211-99214). The department uses the CPT® definitions for *new* and *established* patients. If a provider has treated a patient for any reason within the last three years, the person is considered an *established patient*. Refer to a CPT® book for complete code descriptions, definitions and guidelines.

New Patient E/M Payment Policies

The following payment policies apply when chiropractic physicians use E/M new patient office visit codes for the initial visit for a new work injury:

- A new patient E/M office visit code is payable only once for the initial visit.
- Modifier -22 is not payable with E/M codes for chiropractic services.
- New patient E/M office visit codes are payable with L&I chiropractic care codes **only when all of the following conditions are met:**
  1. The E/M service constitutes a significant separately identifiable service that exceeds the usual pre- and post-service work included in the chiropractic care visit, and
  2. Modifier 25 is added to the new patient E/M code, and
  3. Supporting documentation describing the service(s) provided is in the patient's record.

Established Patient E/M Payment Policies

The following payment policies apply when chiropractic physicians use E/M established patient office visit codes for the initial visit for a new work injury:

- An established patient E/M office visit code is not payable on the same day as a new patient E/M office visit code.
- Office visits in excess of 20 visits or 60 days require prior authorization.
- Modifier -22 is not payable with E/M codes for chiropractic services.
- Established patient E/M codes are not payable in addition to L&I chiropractic care codes for follow-up visits.
- Established patient E/M codes are payable in addition to L&I chiropractic care codes **only when all of the following conditions are met:**
  1. The E/M service is for the *initial visit* for a *new claim*, and
  2. The E/M service constitutes a significant separately identifiable service that exceeds the usual pre- and post-service work included in the chiropractic care visit, and
  3. Modifier -25 is added to the new patient E/M code, and
  4. Supporting documentation describing the service(s) provided is in the patient's record.

When a patient requires re-evaluation for an existing claim, either an established patient E/M code (99211-99214) or a chiropractic care local code (2050A-2052A) is payable. Payment will not be made for both. Modifier -25 is not applicable in this situation.

Chiropractic Care Visits

Billing Codes

The department has developed the following clinical complexity based local codes for chiropractic care visits. CPT® codes for chiropractic manipulative treatment (98940-98943) are not covered.

2050A Level 1: Chiropractic Care Visit (straightforward complexity) ..... $ 35.81

2051A Level 2: Chiropractic Care Visit (low complexity) ..... $ 45.87

2052A Level 3: Chiropractic Care Visit (moderate complexity) ..... $ 55.88

Chiropractic care visits are defined as office or other outpatient visits involving subjective and objective assessment of patient status. The table below outlines the treatment requirements, presenting problems and face-to-face patient time involved in the three levels of chiropractic care visits.

Clinical decision making complexity is the primary component in selecting the level of chiropractic care visit. The department defines clinical decision making complexity according to the definitions for medical decision making complexity in the *Evaluation and Management Services Guidelines* section of the CPT® book.

	2050A: Level 1	**2051A: Level 2**	**2052A: Level 3**
Primary: Clinical decision making is typically:	Straightforward	Low complexity	Moderate complexity
Typical number of body regions manipulated	Up to 2	Up to 3 or 4	Up to 5 or more
Typical face-to-face time with patient and/or family	Up to 10-15 minutes	Up to 15-20 minutes	Up to 25-30 minutes

Body regions for chiropractic services are defined as:

- Cervical (includes atlanto-occipital joint);
- Thoracic (includes costovertebral and costotransverse joints);
- Lumbar;
- Sacral;
- Pelvic (includes sacro-iliac joint); and
- Extraspinal: Any and all extraspinal manipulations are considered to be one region. Extraspinal manipulations include head (including temporomandibular joint, excluding atlanto-occipital), lower extremities, upper extremities, rib cage (excluding costotransverse and costovertebral joints).

The following examples of chiropractic care visits are for illustrative purposes only. They are not intended to be clinically prescriptive.

EXAMPLES	
Level 1 Chiropractic Care Visit (straightforward complexity)	26-year-old male presents with mild low back pain of several days duration. Patient receives manipulation/adjustment of the lumbar region
Level 2 Chiropractic Care Visit (low complexity)	55-year-old male presents with complaints of neck pain, midback and lower back pain. Patient receives 5 minutes of myofascial release prior to being adjusted. The cervical, thoracic and lumbar regions are adjusted.
Level 3 Chiropractic Care Visit (moderate complexity)	38-year-old female presents with headache, right anterior rib pain, low back pain with pain at the sacrococcygeal junction, as well as pain in the sacroiliac regions and right sided foot drop. Patient receives 10 minutes of moist heat application, 10 minutes of myofascial work, and manipulation/adjustment to the cervical and atlanto-occipital, thoracic, anterior rib area, lumbar, sacroiliac and sacrococcygeal regions.

Chiropractic Care Visit Payment Policies

- Only **one** chiropractic care visit code is payable per day.
- Office visits in excess of 20 visits or 60 days require prior authorization.
- Modifier -22 will be individually reviewed when billed with chiropractic care visit local codes (2050A-2052A). A report is required detailing the nature of the unusual service and the reason it was required. Payment will vary based on findings of the review. No payment will be made when this modifier is used for non-covered or bundled services (for example: application of hot or cold packs).
- Chiropractic care visit codes are payable in addition to E/M office visit codes only when all of the following conditions are met:
  1. The E/M service is for the initial visit for a new claim, and
  2. The E/M service constitutes a significant separately identifiable service that exceeds the usual pre- and post-service work included in the chiropractic care visit, and
  3. Modifier -25 is added to the new patient E/M code, and
  4. Supporting documentation is included in the patient's record.

Complementary and Preparatory Services

Chiropractic physicians are not separately paid for patient education or complementary and preparatory services. The department defines complementary and preparatory services as interventions that are used to prepare a body region for or facilitate a response to a chiropractic manipulation/adjustment. The application of heat or cold is considered a complementary and preparatory service.

For Example: Routine patient counseling regarding lifestyle, diet, self-care and activities of daily living, thermal modalities or some soft tissue work, exercise instruction involving a provision of a sheet of home exercises and a description in the course of a routine office visit.

Physical Medicine Treatment

The CPT® physical medicine codes (97001-97799) are not payable to chiropractic physicians. Refer to "Non-Board Certified/Qualified Physical Medicine Providers" for more information.

Case Management

Refer to "Case Management Services" in the "Evaluation and Management" section for information on billing for case management services. These codes may be paid in addition to other services performed on the same day.

Consultations

Approved chiropractic consultants may bill the first four levels of CPT® office consultation codes (99241-99244). The department annually publishes a Provider Bulletin describing the department's policy on consultation referrals. The bulletin also includes a list of approved chiropractic consultants. To obtain the most recent bulletin, call the department's Provider Hotline at 1-800-848-0811.

Chiropractic Independent Medical Exams

Chiropractic physicians must be on the Approved Examiners List to perform independent medical exams (IMEs). To be considered for placement on the Approved Examiners List, a chiropractic physician must have all of the following:

- Two years experience as a chiropractic consultant on the department's approved consultant list,
- Successfully completed the department's annual disability rating course for Washington State,
- Attended the department's annual Chiropractic Consultant Seminar during the previous 12 months,
- Submitted the written examination required for certification.

For more information, refer to the *Medical Examiners' Handbook* (publication #F252-001-000).

Chiropractic physicians performing impairment ratings on their own patients or upon referral should refer to the *Medical Examiners' Handbook* and "Impairment Rating by Attending Doctors/Consultants" later in this section.

Supplies

Refer to the "Supplies, Materials, and Bundled Services" section for information about billing for supplies.

Radiology Services

Chiropractic physicians should bill diagnostic x-ray services using CPT® radiology codes and the policies described in the "Radiology Services" section. If needed, x-rays immediately prior to and immediately following the initial chiropractic adjustment may be allowed without prior authorization. X-rays subsequent to the initial study require prior authorization.

Only chiropractic physicians who are on the department's list of approved radiological consultants may bill for x-ray consultation services. To qualify, a chiropractic physician must

be a Diplomate of the American Chiropractic Board of Radiology and must be approved by the department.

MASSAGE THERAPY

Massage therapists will be paid for CPT® code 97124 for all forms of massage therapy, regardless of the technique used. The department will not pay massage therapists for additional codes.

Massage therapists should bill their usual and customary fee and designate the duration of the massage therapy treatment. Massage is a physical medicine service and is subject to the daily maximum allowable amount of $102.65.

The application of hot or cold packs (CPT® code 97010), anti-friction devices, and lubricants (e.g. oils, lotions, emollients, etc.) are bundled into the massage therapy service and are not payable separately.

Refer to WAC 296-23-250 for additional information.

Massage therapy services should be billed in 15-minute time increments. Bill one unit of CPT® code 97124 for each 15 minutes of massage therapy.

ELECTRICAL NERVE STIMULATORS

Transcutaneous Electrical Nerve Stimulators (TENS)

Rental and Purchase of TENS

TENS units and supplies for State Fund injured workers are provided under contract. TENS units may be prescribed by licensed medical, osteopathic, naturopathic and podiatric physicians and dental surgeons. All providers who prescribe TENS units for State Fund injured workers must use the department's contracted vendor. Refer to Provider Bulletin 01-11 for more information about TENS rental and purchase for State Fund claims.

- TENS use requires prior authorization by the insurer. Call the Provider Hotline at 1-800-848-0811 for authorization.
- A trial evaluation period of up to 30 days is required. During this time, the provider and injured worker will assess whether the TENS treatment is working and if rental of the unit is medically necessary.
- If the TENS is beneficial for the injured worker, a four-month rental period may be approved.
- Following a four month rental period, the provider may submit a request for TENS purchase for consideration by the insurer.

TENS Billing Codes

The department's contracted vendor and providers treating Self-Insured workers should use the appropriate HCPCS codes to bill for TENS units and supplies.

Sales tax and delivery charges are not separately payable and should be included in the total charge for the TENS unit and supplies.

HCPCS Code	Description	Coverage Status
A4595	TENS Supplies	For State Fund claims: Payable only to the department's contracted vendor. For Self-Insured and Crime Victims claims: Payable to DME suppliers.
A4630	Replacement batteries	
E0730	TENS, four lead, larger area, multiple nerve stimulation	

TENS Application

The department allows the initial TENS application and training by a physical therapist or other qualified provider only once per claim. Use CPT® code 64550.

Electrical Stimulators Used in the Office Setting

Providers using stimulators in the office setting may bill professional services for application of stimulators with the CPT® physical medicine codes when such application is within the provider's scope of practice.

Devices and Supplies for Home Use or Surgical Implantation

The following devices or supplies are intended for home use or surgical implantation.

HCPCS Code	Description	Coverage Status
A4365	Adhesive remover	Bundled for physician office use. Payable only for home use.
A4455	Adhesive remover wipe	
A4556	Electrodes	
A4557	Lead wires	
A4558	Conductive paste or gel	
A5119	Skin barrier wipes	
A6250	Skin seal protect moisturizer	
E0745	Neuromuscular stimulator electric shock unit	Covered for home use for muscle denervation only. Prior authorization is required.
E0747	Osteogenic stimulator, electrical, non-invasive, other than spinal applications	Prior authorization is required.
E0749	Osteogenic stimulator, electrical (surgically implanted)	Authorization subject to utilization review.
E0760	Osteogenic stimulator, low intensity, ultrasound, non-invasive	Prior authorization is required. For appendicular skeleton only (not the spine).
E0731	Form fitting conductive garment for TENS or NMES	Not Covered
E0740	Incontinence treatment system	
E0744	Neuromuscular stimulator for scoliosis	
E0748	Osteogenic stimulator, electrical, non-invasive, spinal applications	
E0753	Implantable neurostimulator electrodes, per group of four	
E0755	Electronic salivary reflex stimulator	

PSYCHIATRIC SERVICES

The psychiatric services policies in this section apply only to workers covered by the State Fund and Self-Insured employer workers (see WAC 296-21-270). For information on psychiatric policies applicable to the Crime Victims Compensation Program, refer to the department's booklet *Mental Health Treatment Rules and Fees* and WAC 296-31.

PROVIDERS OF PSYCHIATRIC SERVICES

Authorized psychiatric services **must** be performed by either a psychiatrist (MD or DO) or a licensed psychologist (PhD), per WAC 296-21-270. Licensed clinical psychologists and psychiatrists are paid at the same rate when performing the same service. Each provider must obtain his or her own L&I provider account number for billing and payment purposes.

The department does not cover psychiatric evaluation and treatment services provided by social workers, psychiatric nurse practitioners, and other master's level counselors, even when delivered under the direct supervision of a clinical psychologist or a psychiatrist. Staff supervised by a psychiatrist or licensed clinical psychologist may administer psychological testing; however, the psychiatrist or licensed clinical psychologist must interpret the testing and prepare the reports.

PSYCHIATRISTS AS ATTENDING PHYSICIANS

A psychiatrist can only be an injured worker's attending physician when the department has accepted a psychiatric condition and it is the **only** condition being treated. Psychologists cannot be the attending physician and may not certify time loss or rate Permanent Partial Disability under department rules (WAC 296-20-210).

NON-COVERED AND BUNDLED SERVICES

The following services are not covered:

CPT® Code	Abbreviated Description
90802, 90810-90815, 90823-90829 and 90857	Interactive psychiatric interview/exam and interactive psychotherapy
90845	Psychoanalysis
90846	Family psych w/o patient
90849	Multiple family group psych tx

The following services are bundled and are not payable separately:

CPT® Code	Abbreviated Description
90885	Psy evaluation of records
90887	Consultation with family
90889	Preparation of report

PSYCHIATRIC CONSULTATIONS AND EVALUATIONS

All referrals for psychiatric care require prior authorization (per WAC 296-21-270). This requirement includes referrals for psychiatric consultations and evaluations.

When an authorized referral is made to a psychiatrist, the psychiatrist may bill either the evaluation and management consultation codes (CPT® codes 99241-99275) or the psychiatric diagnostic interview examination code (CPT® code 90801).

When an authorized referral is made to a clinical psychologist for an evaluation, the psychologist may bill only the psychiatric diagnostic interview exam code (CPT® code 90801).

Authorization for CPT® code 90801 is limited to one occurrence every six months, per patient, per provider.

Refer to WAC 296-20-045 and WAC 296-20-051 for more information on consultation requirements.

CASE MANAGEMENT SERVICES

Psychiatrists and clinical psychologists may only bill for case management services (CPT® codes 99361, 99362, and 99371-99373) when providing consultation or evaluation.

Refer to "Case Management Services" in the "Evaluation and Management" section for payment criteria and documentation requirements for case management services.

INDIVIDUAL INSIGHT ORIENTED PSYCHOTHERAPY

Individual insight oriented psychotherapy services are divided into services *with* an evaluation and management (E/M) component, and services *without* an E/M component. Coverage of these services is different for psychiatrists and clinical psychologists.

Psychiatrists may bill individual insight oriented psychotherapy codes either *with* or *without* an evaluation and management component (CPT® codes 90804-90809, 90816-90819 and 90821-90822). Psychotherapy *with* an E/M component may be billed when services such as medical diagnostic evaluation, drug management, writing physician orders, and/or interpreting laboratory or other medical tests are conducted along with psychotherapy treatment.

Clinical psychologists may bill only the individual insight oriented psychotherapy codes *without* an E/M component (CPT® codes 90804, 90806, 90808, 90816,90818 and 90821). They may not bill psychotherapy with an E/M component because medical diagnostic evaluation, drug management, writing physician orders, and/or interpreting laboratory or other medical tests are outside the scope of clinical psychologist licensure.

Further explanation of this policy and CMS's response to public comments about it are published in *Federal Register* Volume 62 Number 211, issued on October 31, 1997.

Billing Tip

To report individual psychotherapy, use the time frames in the CPT® code descriptions for each unit of service. When billing these codes, do not bill more than one unit per day. When the time frame is exceeded for a specific code, bill the code with the next highest time frame.

USE OF CPT⊇ EVALUATION AND MANAGEMENT CODES FOR OFFICE VISITS

Psychologists may not bill the E/M codes for office visits.

Psychiatrists may not bill the E/M codes for office visits on the same day psychotherapy is provided for the same patient. If it becomes medically necessary for the psychiatrist to provide an E/M service for a condition other than that for which psychotherapy has been authorized, the provider must submit documentation of the event and request a review before payment can be made.

PHARMACOLOGICAL EVALUATION AND MANAGEMENT

Pharmacological evaluation (CPT® code 90862) is payable only to psychiatrists. If a pharmacological evaluation is conducted on the same day as individual psychotherapy, the psychiatrist should bill the appropriate psychotherapy code with and E/M component. The psychiatrist should not bill the individual psychotherapy code and a separate E/M code in this case (CPT® codes 99201-99215). No payment will be made for psychotherapy and pharmacological management services performed on the same day, by the same physician, on the same patient.

HCPCS code M0064 is not payable in conjunction with the pharmacological evaluation code (CPT® code 90862) or with a (CPT® Evaluation and Management office visit or consultation code (CPT® codes 99201-99215, 99241-99275). The description for HCPCS code M0064 is "Brief office visit for the sole purpose of monitoring or changing drug prescriptions used in treatment of mental psychoneurotic and personality disorders." It will only be payable if these described conditions are accepted by the department as industrially related.

NEUROPSYCHOLOGICAL TESTING

The following three codes may be used if appropriate when performing neuropsychological evaluation. Reviewing records and/or writing and submitting a report is included in these codes and may not be billed separately.

CPT® Code	Abbreviated Description	Billing Restriction
90801	Psy dx interview	May be billed only once every six months.
96100	Psychological testing/per hour	May be billed up to a four hour maximum. May be billed in addition to CPT® code 96117.
96117	Neuropsychological testing/per hour	May be billed per hour up to a twelve hour maximum.

GROUP PSYCHOTHERAPY SERVICES

Group psychotherapy treatment (CPT® code 90853) is authorized on an individual case by case basis only. If authorized, the worker may participate in group therapy as part of his or her individual treatment plan. The department does not pay a "group rate" to providers who conduct psychotherapy exclusively for groups of injured workers.

If group psychotherapy is authorized and performed on the same day as individual insight oriented psychotherapy (with or without an E/M component), both services may be billed, as long as they meet the CPT® definitions.

NARCOSYNTHESIS AND ELECTROCONVULSIVE THERAPY

Narcosynthesis (CPT® code 90865) and electroconvulsive therapy (CPT® codes 90870 and 90871) require prior authorization. Authorized services are payable only to psychiatrists because they require the administration of medication.

OTHER MEDICINE SERVICES

BIOFEEDBACK

Biofeedback treatment requires an attending doctor's order and prior authorization. Refer to WAC 296-20-03001 for information on what to include when requesting authorization. Rental of home biofeedback devices are time limited and require prior authorization. Refer to WAC 296-20-1102 for the department's policy on rental equipment.

The extent of biofeedback treatment is limited to those procedures allowed within the scope of practice of the licensed and approved biofeedback provider administering the service.

WAC 296-21-280 limits provision of biofeedback to those practitioners who are either certified by the Biofeedback Certification Institute of America (BCIA) or who meet the certification requirements. The WAC also sets forth authorization conditions, treatment limitations and reporting requirements for biofeedback services.

Anyone who is a qualified or certified biofeedback provider as defined in WAC 296-21-280, but is not licensed as a practitioner as defined in WAC 296-20-01002 may not receive direct payment for biofeedback services. These persons *may perform* biofeedback as a para-professional as defined in WAC 296-20-015 under the direct supervision of a qualified, licensed practitioner whose scope of practice includes biofeedback and who is BCIA certified or who meets the certification qualifications. The supervising licensed practitioner must bill the biofeedback services.

When biofeedback is performed in conjunction with individual psychotherapy, use either CPT® code 90875 or 90876 for psychophysiological therapy; do not bill CPT® codes 90901 or 90911 with the individual psychotherapy codes.

The following table contains the biofeedback codes payable to approved providers:

Code	Abbreviated Description	Payable to:	Maximum Fee
CPT® 90875	Psychophysiological thrpy 20-30 min	Department approved biofeedback providers who are: Clinical Psychologists or Psychiatrists (MD or DO).	See Professional Services Fee Schedule
CPT® 90876	Psychophysiological thrpy 45-50 min		
CPT® 90901	Biofeedback, any modality	Any department approved biofeedback provider	
CPT® 90911	Biofeedback peri/uro/rectal		
HCPCS E0746	Electromyography (EMG) biofeedback device	DME or pharmacy providers (for rental or purchase). Bundled for RBRVS providers for use in the office.	
Local 1042M	Biofeedback initial eval, 1 hr, includes report	Any department approved biofeedback provider	$ 126.64
Local 1043M	Biofeedback follow-up eval, 30 min, includes report		$ 63.32

Note: CPT® codes 90901 and 90911 are not time limited and only one unit of service per day is payable, regardless of the length of the biofeedback session or number of modalities. The local codes for diagnostic evaluation (1042M and 1043M) are payable in addition to treatment on the same day. Initial evaluation is limited to once per claim per provider.

ELECTROMYOGRAPHY (EMG) SERVICES

Payment for needle electromyography (EMG) services (CPT® codes 95860-95870) is limited as follows:

CPT® Code	Abbreviated Description	Limitations
95860	Muscle test, one limb	≠ Extremity muscles innervated by 3 nerves or 4 spinal levels must be evaluated with a minimum of 5 muscles studied. ≠ Not payable with CPT® code 95870
95861	Muscle test, two limbs	
95863	Muscle test, 3 limbs	
95864	Muscle test, 4 limbs	
95869	Muscle test, thoracic paraspinal	≠ May be billed alone (for thoracic spine studies only) ≠ Limited to one unit per day ≠ For this to pay with extremity codes, test must be for T3-T11 areas only; if only T1 or T2 are studied it is not payable separately.
95870	Muscle test, non-paraspinal	≠ Limited to one unite per extremity and one unit for cervical or lumbar paraspinal muscles regardless of the number of levels tested. ≠ Not payable with extremity codes. (5 units maximum payable)

ELECTROCARDIOGRAMS (EKG)

Separate payment is allowed for electrocardiograms (CPT® codes 93000, 93010, 93040 and 93042) when an interpretation and report is included. These services may be paid in conjunction with office services. EKG tracings without interpretation and report (CPT® codes 93005 and 93041) are not payable in addition to office services.

Transportation of portable EKG equipment to a facility or other patient location (HCPCS code R0076) is bundled into the EKG procedure and is not separately payable.

VENTILATOR MANAGEMENT SERVICES

No payment will be made for ventilator management services (CPT® codes 94656, 94657, 94660 and 94662) when an E/M service (CPT® codes 99201-99215) is reported on the same day by the same provider. Providers will be paid for either the appropriate ventilation management code or the E/M service, but not both. If a provider bills a ventilator management code on the same day as an E/M service, payment will be made for the E/M service and not for the ventilator management code.

MEDICATION ADMINISTRATION

Immunizations

Refer to WAC 296-20-03005 for authorization and requirements for work related exposure to an infectious disease. If authorized, immunization materials are payable. Immunization administration codes (CPT® codes 90471 and 90472) are payable in addition to the immunization materials code(s). Add-on CPT® code 90472 has a maximum daily fee of $5.44.

An E/M code is not payable in addition to the immunization administration service, unless it is performed for a separately identifiable purpose and billed with a -25 modifier.

Immunotherapy

Professional services for the supervision and provision of antigens for allergen immunotherapy must be billed as component services. Complete service codes (CPT® codes 95120 – 95134) will not be paid. The provider must bill as appropriate, one of the injection codes (CPT® codes 95115 or 95117) and one of the antigen/antigen preparation codes (CPT® codes 95145 – 95149, 95165 or 95170).

Infusion Therapy Services and Supplies for RBRVS Providers

Prior authorization is required for any scheduled or ongoing infusion therapy services (including supplies) performed in the office, clinic, or home, regardless of who performs the service (e.g. physicians, nurses, IV infusion therapy company, pharmacy or home health agency). Refer to the "Home Health Services" section for further information on home infusion therapy.

Outpatient infusion therapy services are allowed without prior authorization when medically necessary to treat urgent or emergent care situations that arise in an office or clinic. In these situations, infusion therapy services are payable to physicians, ARNPs, and PAs (CPT® codes 90780 and 90781). HCPCS code Q0081 is only payable to hospitals. Intravenous or intra-arterial therapeutic or diagnostic injection codes (CPT® codes 90783 and 90784) will not be paid separately in conjunction with the IV infusion codes (CPT® codes 90780 and 90781).

Providers will be paid for E/M office visits (CPT® codes 99201 – 99215) in conjunction with infusion therapy only if the services provided meet the service code definitions.

Billing instructions for non-pharmacy providers are located in "Injectable Medications" later in this section. Drugs supplied by a pharmacy should be billed on pharmacy forms with national drug codes (NDCs, or UPCs if no NDC is available).

Infusion therapy supplies and related durable medical equipment such as infusion pumps are not separately payable for RBRVS providers. Payment for these items is bundled into the fee for the professional service. If rental or purchase of an infusion pump is medically necessary to treat a patient in the home, refer to the "Home Health Services" section for further information.

The department does ***not*** cover implantable infusion pumps and supplies (HCPCS codes A4220, E0782, E0783, and E0785). The department also does ***not*** cover the implantation of epidural or intrathecal catheters, including their revision, repositioning, replacement, or removal (CPT® codes 62350 – 62368).

Note: When a spinal cord injury is an accepted condition, the department or Self-Insurer may authorize payment for anti-spasticity medications by any indicated route of administration (e.g., some benzodiazepines, Baclofen). Prior authorization is required.

Placement of non-implantable epidural or subarachnoid catheters for single or continuous injection of mediations are covered services with CPT® 62310 – 62319, 62281 – 62284 and 62290 – 62294.

Intrathecal and epidural infusions of any substance other than anesthetic or contrast material are not covered (per WAC 296-20-03002). Infusion of any opiates and their derivatives (natural, synthetic or semi-synthetic) are not covered unless they are part of providing anesthesia, short term post operative pain management (up to 48 hours post discharge), or unless medically necessary in emergency situations (per WAC 296-20-03014). No exceptions to this payment policy will be granted.

Therapeutic or Diagnostic Injections

Professional services associated with therapeutic or diagnostic injections (CPT® code 90782 or 90788), are payable along with the appropriate HCPCS "J" code for the drug, as long as no E/M office visit service (CPT® codes 99201 – 99215) is provided on the same day. If an E/M office visit service is provided on the same day as an injection, providers will be paid only the E/M service and the appropriate HCPCS "J" code for the drug. Providers must document the name, strength, dosage and quantity of the drugs administered in the medical record.

Intra-arterial and intravenous diagnostic and therapeutic injection services (CPT® codes 90783 and 90784) may be billed separately and are payable if they are not provided in conjunction with IV infusion therapy services (CPT® codes 90780 and 90781).

Note: Injections of narcotics or analgesics are not permitted or paid in the outpatient setting except on an emergency basis per WAC 296-20-03014 (6), or for pain management related to outpatient surgical procedures and dressing and cast changes for severe soft tissue injuries, burns or fractures.

"Dry needling" is considered a variant of trigger point injections with medications. Dry needling is a technique where needles inserted (no medications are injected) directly into trigger point locations as opposed to the distant points or meridians used in acupuncture. The department does not cover acupuncture services (WAC 296-20-03002). Dry needling of trigger points should be billed using only the trigger point injection code (CPT®20550). Dry needling follows the same rules as trigger point injections in WAC 296-20-03001(14).

Injectable Medications

Providers should use the "J" codes for injectable drugs that are administered during an E/M office visit or other procedure. The "J" codes are not intended for self-administered medications.

When billing for a non-specific injectable drug, the name, strength, dosage and quantity of drug administered or dispensed must be noted on the bill as well as documented in the medical record.

Providers should bill their acquisition cost for the drugs. Department fees for injectable medications are based on the Average Wholesale Prices (AWP). Payment is made according to the published fee schedule amount, or the billed charge for the covered drug(s), whichever is less.

Hyaluronic Acid for Osteoarthritis of the Knee

See Provider Bulletin 98-10 for more information about the use of hyaluronic acid for osteoarthritis of the knee. Only the following local codes should be billed for these services:

3020A	Hyalgan or Supartz incuding injection procedure, per injection (limited to 5 injections per knee joint per claim)	$161.84
3040B	Synvic including injection procedure, per injection (limited to 3 injections per knee joint per claim)	$208.92

The correct side of body modifier (-RT or -LT) will be required for authorization and billing. If bilateral procedures are required, both modifiers should be authorized and each should be billed as a separate line item.

The HCPCS codes for Hyaluronic acid (J7316 and J7320) are not covered and will not be paid. CPT® injection procedure code 20610 will not be paid on the same date as the above local codes.

Non-Injectable Medications

Providers may administer oral or non-injectable medications during office procedures or dispense them for short-term use until the worker can have their prescription filled at a pharmacy. In these cases, providers should bill the distinct "J" code that describes the medication. If no distinct "J" code describes the medication, the most appropriate non-specific HCPCS code listed below should be used:

J3535 Drug administered through a metered dose inhaler
J7599 Immunosuppressive drug, not otherwise classified
J7699 Inhalation solution administered though DME, not otherwise specified
J7799 Other than inhalation drug administered though DME, not otherwise specified
J8499 Prescription drug, oral, non-chemotherapeutic, not otherwise specified
J8999 Prescription drug, oral, chemotherapeutic, not otherwise specified.

The name, strength, dosage and quantity of drug administered or dispensed must be noted on the bill as well as documented in the medical record. No payment will be made for pharmaceutical samples.

HIV Prophylaxis

Insurers will pay for the initial prophylactic drug kit for post HIV exposure when it is dispensed by the treating physician. The kit allows prophylaxis to begin immediately and gives the worker time to get a routine prescription filled. Each kit contains a two-day supply of Combivir and Viracept, or other appropriate antiviral drugs. A maximum of two kits per exposure are payable. A claim must be filed for a documented HIV exposure at work for the kit (s) to be payable. Providers should bill the following local code for the HIV drug kit:

3060A	HIV exposure initial treatment kit	$ 131.50

OBESITY TREATMENT

While obesity does not meet the definition of an industrial injury or occupational disease, temporary treatment of obesity may be allowed in some cases. All obesity treatment services require prior authorization. Refer to Provider Bulletin 97-03 for more information.

The attending doctor may request a consultation with a registered dietician or nutritionist (RD) to determine if an obesity treatment program is appropriate for the injured worker. The following local codes are payable only to RDs.

1030M	Obesity treatment; intake dietary evaluation (limited to one per obesity treatment program)	$ 80.23
1034M	Obesity treatment; dietary re-evaluation (limited to 3 per obesity treatment program)	$ 55.01

IMPAIRMENT RATING BY ATTENDING DOCTORS AND CONSULTANTS

These local codes are for use by attending doctors who are doctors of medicine, osteopathic medicine and surgery, chiropractic, podiatry, and dentistry. In accordance with WAC 296-23-267, doctors of naturopathy and optometry may not bill these codes. For more information on impairment rating, refer to the *Medical Examiners Handbook*.

Consultants performing impairment ratings must be on the department's list of approved examiners.

1190M	Impairment rating by attending doctor, limited	$ 219.43
1191M	Impairment rating by attending doctor, standard	$ 319.18
1192M	Impairment rating by attending doctor, complex	$ 398.96
1193M	Impairment rating by consultant, limited	$ 219.43
1194M	Impairment rating by consultant, standard	$ 319.18
1195M	Impairment rating by consultant, complex	$ 398.96

PHYSICIAN ASSISTANTS

Physician assistants must be certified to qualify for payment. Physician assistants must have valid individual L&I provider account numbers to be paid for services.

Consultations, impairment ratings and administrative or reporting services related to workers' compensation benefit determinations are not payable to physician assistants. Physician assistant services are paid to the supervising physician or employer at a maximum of ninety percent (90%) of the allowed fee.

Further information about physician assistant services and payment can be found in Provider Bulletin 99-04 and WAC 296-20-12501 and WAC 296-20-01501.

NATUROPATHIC PHYSICIANS

Naturopathic physicians should use the local codes listed in this section to bill for office visit services, CPT® codes 99361 – 99373 to bill for case management services and the appropriate HCPCS codes to bill for miscellaneous materials and supplies.

Refer to "Case Management Services" in the "Evaluation and Management" section for payment criteria and documentation requirements for case management services.

The department will not pay naturopathic physicians for services that are not specifically allowed. Refer to WAC 296-23 for additional information.

INITIAL VISITS

2130A	Routine examination, history, and/or treatment (routine procedure), and submission of a report	$44.74
2131A	Extended office visit including treatment – report required	$67.12
2132A	Comprehensive office visit including treatment – report required in addition to the report of accident	$89.51

FOLLOW-UP VISITS

2133A	Routine office visit including evaluation and/or treatment	$35.81
2134A	Extended office visit including treatment – report required	$67.12